DENTAL INSURANCE

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SECTION 1: Dental Insurance Overview

This section of the booklet describes the dental benefits you have under your group coverage. It also explains what payments are made for covered dental expenses. The various covered services you are entitled to referred to as your "benefits." This section explains your dental benefits in general terms. It does not give details on all the terms in your group contract. In the event of a conflict between the group contract and this section, the terms of the contract will prevail.

SECTION 2: Eligibility

Full-time IAFF employee's eligibility for dental benefits will begin the first of the month following ninety (90) days after the date of hire.

SECTION 3: Dental Payments

If your dentist is a participating dentist, Delta Dental will base payment on the maximum approved fee for covered services.

Delta Dental will send payment directly to participating dentists and you will be responsible for any applicable copayments or deductibles. Unless prohibited by state law, you will be responsible for the maximum approved fee for most commonly performed non-covered services. For other non-covered services, you will be responsible for the dentist's submitted amount.

If your dentist is a nonparticipating dentist, Delta Dental will base payment on the nonparticipating dentist fee for covered services.

If your dentist is an out-of-country dentist, Delta Dental will base payment on the out-of-country dentist fee for covered services.

For covered services rendered by a nonparticipating dentist or out-of-country dentist, Delta Dental will usually send payment to you, and you will be responsible for making full payment to the dentist. You will be responsible for any difference between Delta Dental's payment and the dentist's submitted amount

Maximum Approved Fee

A system to determine the approved fee for a given procedure for a given participating dentist. A fee meets maximum approved fee requirements if it is the lowest of:

- The submitted amount.
- The lowest fee regularly charged, offered, or received by an individual dentist for a dental service or supply, irrespective of the dentist's contractual agreement with another dental benefits organization.

- The maximum fee that the local Delta Dental plan approves for a given procedure in a given region and/or specialty, under normal circumstances, based upon applicable participating dentist schedules and internal procedures.

Delta Dental may also approve a fee under unusual circumstances. Participating dentists agree not to charge Delta Dental patients more than the maximum approved fee for a covered service. In all cases, Delta Dental will make the final determination regarding the maximum approved fee for a covered service.

In some situations, there may be more than one way to treat a dental condition. When there is a choice of treatments which meet accepted standards of dental practice, Delta Dental will base payment on the least costly, even if you or your dentist choose a more costly way. For example, suppose you choose to have a bridge made rather than a removable partial denture. Delta Dental may choose to base payment to you on the usual cost of a partial denture, if this would provide an adequate and appropriate level of care. You and your dentist may decide to have the bridge made anyway, at which time you may apply the benefits this program has allowed toward the cost of the bridge.

This program will not pay more than the actual fees charged for any dental treatment or dental fees that are over the maximum approved fee.

Selecting a Dentist

You may choose any dentist. Your out-of-pocket costs are likely to be less if you go to a Delta Dental PPO dentist. PPO dentists agree to accept payment according to the PPO dentist schedule and, in most cases, this results in a reduction of their fees. Your summary of dental plan benefits may also show that your copayments or deductibles are higher for covered services from a non-PPO dentist. If the dentist you select is not a PPO dentist, you will still be covered, but you may have to pay more.
If you go to a non-PPO dentist who participates in Delta Dental premier, you will be responsible for any copayment or deductible up to the maximum approved fee.

If you choose a dentist who does not participate in either program, you will be responsible for any difference between the nonparticipating dentist fee and the dentist's submitted fee, in addition to any copayment or deductible.

To verify that a dentist is a participating dentist, you can use Delta Dental's online dentist directory at www.deltadentaloh.com or call (800) 524-0149.

SECTION 4: Applying For Benefits

To use your plan, follow these steps:

- Please read this summary plan description carefully so you are familiar with the benefits, payment mechanisms, and provisions of your plan.

- Make an appointment with your dentist and tell him or her that you have dental benefits coverage with Delta Dental. If your dentist is not familiar with your plan or has questions about the plan, have him or her contact Delta Dental by writing or calling the toll-free number:

  Delta Dental, attention: Customer Service
  P.O. Box 9089
  Farmington Hills, Michigan 48333- 9089
  (800) 524-0149.H

- After you receive your dental treatment, you or the dental office staff will file a claim form, completing the information portion with:
  - The subscriber's full name and address;
  - The subscriber's member id number;
  - The name and date of birth of the person receiving dental care;
  - The group's name and number.

- Claims and completed information requests should be mailed to:
  Delta Dental
  P.O. Box 9085
  Farmington hills, mi 48333-9085

- The completed claim form must be submitted to Delta Dental within 90 days after the services or supplies are provided to you. If you have a valid reason for submitting your claim after the time limit, your claim will be handled in the usual way--provided that you submit it as soon as possible. No claims should be submitted later than 12 months after the usual 90-day filing period ends.

- Your bill must be submitted within the 12 month limit for filing claims.

- Note: if your claim is for dental services for an injury resulting from an accident or the dental procedures listed in the medical section under dental surgery, you should first file a medical claim. After you receive payment from your medical coverage, file a dental claim and attach a copy of the medical payment voucher. This program will then consider any balance under your dental coverage.

Questions about Your Benefits or Appeals

It is your responsibility to determine if services rendered are covered under the contract.

If you contact the service unit, be sure to keep records of such things as:

- The date of contact;
- The name of the company representative; and
- The response you were given. If you have questions, contact:
  Delta Dental
  Box 9085

Farmington Hills, MI 48333-9085
1-800-524-0149
Website: www.deltadentaloh.com

SECTION 5: General Provisions

This section describes how your coverage works, including:

- How and when coverage terminates;
- Extension of benefits.

Riders, Endorsements, or Amendments

Because of some state laws or the special needs of your group, provisions called "riders," "endorsements," or "amendments" may be added to your booklet. "riders," "endorsements," or "amendments" change provisions or benefits in your booklet.

Contract Maximum

The maximum amount this contract will pay for covered dental expenses, except orthodontics, for one person in one benefit year is: $1,500

The benefit year is the same as the calendar year, January 1st through December 31st.

Orthodontic Lifetime Maximum

The lifetime maximum payable for orthodontia services for a subscriber's eligible dependent is $1,850.

The yearly maximum for all other covered services shall not apply to orthodontia.

Predetermination of Benefit

If your dentist plans a course of treatment which is expected to cost $250 or more, you should have him or her submit the treatment program to Delta Dental on a claim form before starting work. Your dentist should include a description of the work to be done and an estimate of the charges. X-rays and other diagnostic aids should be included with the treatment program to help Delta Dental determine appropriate benefits. If your dentist submits these aids, you will know exactly what your benefits will be before the treatment begins.

Summary of Dental Benefits

See summary of benefits included in this booklet

Explanation of Benefits

After your claim has been processed, you will receive an explanation of benefits (EOB) telling what has been paid by Delta Dental. You will be billed directly for any amount due.

Amounts Payable

This program will not pay more than the actual charge for covered services.

Return of Payments

Any payment made in error by Delta Dental to the employee, to the group or to a dentist shall be returned to Delta Dental.

Dental Examinations

After you have filed a claim, Delta Dental has the right to ask that you have one or more additional dental examinations. These exams will be at the program's expense and will help to determine what benefits will be paid, particularly when there are questions about services or supplies on your claim.

By accepting coverage under this contract, you agree that Delta Dental may request any dental information or records related to your claims. You authorize any dentist or dental hygienist who provided services to release any necessary information and/or records to Delta Dental. You also agree that any other person or organization can release information related to your diagnosis, treatment or service.

Dental Providers

To be covered under this contract, services and supplies must be provided by a dentist or dental hygienist working within the scope of his or her license. A dentist is a person licensed to practice dentistry. A dental hygienist is a person who is licensed to practice dental hygiene and is working under the supervision and direction of a dentist. All services must be based on accepted standards of dental practice as determined by the American Dental Association. They must be billed by or for a dentist. The services must also be connected with the diagnosis and treatment of the covered person's condition and not be solely for the convenience of the covered person or dentist.

Claims Appeal Procedure

If you receive notice of an adverse benefit determination and you think that Delta Dental incorrectly denied all or part of your claim, you or your dentist should contact Delta Dental’s customer service department and ask them to check the claim to make sure it was processed correctly. You may do this by calling the toll-free number, (800) 524-0149, and speaking to a telephone advisor. You may also mail your inquiry to the: Customer Service Department at P.O. Box 9089, Farmington Hills, Michigan, 48333-9089.

When writing, please enclose a copy of your explanation of benefits and describe the problem. Be sure to include your name, telephone number, the date, and any information you would like

considered about your claim. This inquiry is not required and should not be considered a formal request for review of a denied claim. Delta Dental provides this opportunity for you to describe problems, or submit an explanation or additional information that might indicate your claim was improperly denied, and allow Delta Dental to correct any errors quickly and immediately.

Whether or not you have asked Delta Dental informally to recheck its initial determination, you can request a formal review using the formal claims appeal procedure described below.
Formal claims appeal procedure

If you receive notice of an adverse benefit determination, you, or your authorized representative, should seek a review as soon as possible, but you must file your request for review within 180 days of the date that you received that adverse benefit determination. To request a formal review of your claim, send your request in writing to:

Dental Director
Delta Dental
P.O. Box 30416
Lansing, Michigan 48909-7916

Please include your name and address, the subscriber's member id, the reason why you believe your claim was wrongly denied, and any other information you believe supports your claim. You also have the right to review the contract between Delta Dental and your employer or organization and any documents related to it. If you would like a record of your request and proof that Delta Dental received it, mail your request certified mail, return receipt requested.

The dental director or any person reviewing your claim will not be the same as, nor subordinate to, the person(s) who initially decided your claim. The reviewer will grant no deference to the prior decision about your claim. The reviewer will assess the information, including any additional information that you have provided, as if he or she were deciding the claim for the first time. The reviewer's decision will take into account all comments, documents, records and other information relating to your claim even if the information was not available when your claim was initially decided.

If the decision is based, in whole or in part, on a dental or medical judgment (including determinations with respect to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate), the reviewer will consult a dental health care professional with appropriate training and experience, if necessary. The dental health care professional will not be the same individual or that person's subordinate consulted during the initial determination.
The reviewer will make a determination within 60 days of receipt of your request. If your claim is denied on review (in whole or in part), you will be notified in writing. The notice of an adverse benefit determination during the formal claims appeal procedure will meet the requirements described below.

Manner and Content of Notice

Your notice of an adverse benefit determination will inform you of the specific reasons(s) for the denial, the pertinent plan provisions(s) on which the denial is based, the applicable review procedures for dental claims, including time limits and that, upon request, you are entitled to access all documents, records and other information relevant to your claim free of charge. This notice will also contain a description of any additional materials necessary to complete your claim, an explanation of why such materials are necessary, and a statement that you have a right to bring a civil action in court if you receive an adverse benefit determination after your claim has been completely reviewed according to this formal claims appeal procedure. The notice will also reference any internal rule, guideline, protocol, or similar document or criteria relied on in making the adverse benefit determination, and will include a statement that a copy of such rule, guideline or protocol may be obtained upon request at no charge. If the adverse benefit determination is based on a matter of medical judgment or medical necessity, the notice will also contain an explanation of the scientific or clinical judgment on which the determination was based, or a statement that a copy of the basis for the scientific or clinical judgment can be obtained upon request at no charge.

Liability

The City of Columbus does not select a dentist for you. The city is not responsible or liable for any acts, omissions, or conduct of a dentist or dental hygienist. Delta Dental's only obligation is to make payments to the employee according to contract terms of the group contract.

No action in any court of law may be brought against us sooner than 60 days after your claim was filed or later than three years after the service in question was received.

General Provisions Termination of Group Contract

The group contract may be terminated by the City of Columbus or Delta Dental at any time by giving written notice 60 days prior to the termination date. Your coverage automatically ends upon termination of the group contract.

Automatic Termination

Coverage is not transferable. If the employee tries to transfer this coverage to a person who is not covered, coverage will automatically terminate.

Misrepresentation

If a covered person makes a fraudulent statement, relating to their application for coverage or a claim for benefits, this coverage will become null and void.

Termination due to Loss of Eligibility

Coverage will terminate when you lose your eligibility. Under this contract, coverage will terminate:

- For all covered persons, when the employee loses employment with the group. Coverage will continue until the end of the month of termination.

- For all covered persons when the employee's classification becomes ineligible for coverage under the group contract. Coverage will continue until the end of the month in which the employee became ineligible.
- For the spouse, in the event of an annulment, legal separation, divorce or dissolution.
- For all dependents, in the event of the employee's death, coverage terminates the end of the month in which the employee died.
- For the dependent children when they reach the limiting age, marry or otherwise lose eligibility as a dependent, whichever occurs first.

Extension of Benefits

Benefits will be extended for crowns and prosthodontic services that have been submitted on a claim form for "predetermination" and have been approved by Delta Dental prior to the date of termination of these services. The services must be completed within 60 days of the date of approval by Delta Dental and while the dental program is still in effect. Benefits will also be extended for prosthodontic single procedures that were begun while the employee was eligible. The procedures must be completed before the last day of the month in which eligibility terminated irrespective of predetermination of benefits.

"Single Procedure" means crowns and prosthodontic dental procedures to which a separate procedure number has been assigned in the procedure code and nomenclature list established by the American Dental Association.

SECTION 6: Limitations

The benefits for the following services or supplies are limited as follows, unless otherwise specified in the summary of dental plan benefits. All charges for services or supplies that exceed these limitations will be your responsibility. All time limitations are measured from the applicable prior dates of services in our records with any Delta Dental plan or, at the request of your group, any dental plan:

- Bite-wing x-rays are payable twice in any period of 12 consecutive months. Panoramic or full mouth x-rays (which include bitewing x-rays) are payable once in any three-year period.
- Prophylaxes (cleanings) are payable twice per calendar year. Benefits for periodontal maintenance procedures are unlimited. Full mouth debridement is payable only once in a lifetime.
- Oral examinations and evaluations are payable twice per calendar year, regardless of the dentist's specialty.
- Patient screening is payable once per calendar year.
- Preventive fluoride treatments are payable twice per calendar year with no age limit.
- Space maintainers are payable once per area per lifetime for people under age 19.
- Sealants are payable for the occlusal surface of first and second permanent molars and bicuspids for people under age 19. The surface must be free from decay and restorations.
- Composite resin (white) restorations are covered services on posterior teeth.

- Cast restorations (including jackets, crowns and onlays) and associated procedures (such as core buildups and post substructures) are payable once in any five-year period per tooth.
- Crowns or onlays are payable only for extensive loss of tooth structure due to caries (decay) or fracture.
- Metallic inlays are covered services.
- People under 17 years of age will receive stainless steel or prefabricated crowns only.
- Individual crowns over implants are payable at the prosthodontic benefit level.
- Substructures, porcelain, porcelain substrate, and cast restorations are not payable for people under age 12.
- An interim partial denture is payable only for the replacement of permanent anterior teeth for people under age 17 or during the healing period for people age 17 and over.
- Surgical periodontic services are payable first by the medical carrier, then will be a covered service under this plan secondary to medical.
- Most oral surgical services are payable first by the medical carrier, then will be a covered service under this plan, secondary to medical.
- Antibiotic drug injections are covered services.
- Prosthodontic services limitations:
- One complete upper and one complete lower denture are payable once in any five-year period.
- A removable partial denture, implant or fixed bridge is payable once in any five- year period unless the loss of additional teeth requires the construction of a new appliance.
- Fixed bridges and removable cast partial dentures are not payable for people under age 16.
- A reline or the complete replacement of denture base material is payable once in any three-year period per appliance.
- Implant removal is payable once per lifetime per tooth or area.
- Implant maintenance is payable once per calendar year.
- Orthodontic services limitations:
- Orthodontic services are payable for eligible persons under age 19.
- Treatment must begin prior to age 19 and coverage will continue to the end of treatment or until the maximum has been reached.
- If the treatment plan terminates before completion for any reason, Delta Dental's obligation for payment ends on the last day of the month in which the patient was last treated.
- Upon written notification to Delta Dental and to the patient, a dentist may terminate treatment for lack of patient interest and cooperation. In those cases, Delta Dental's obligation for payment ends on the last day of the month in which the patient was last treated.
- An observation and adjustment is payable twice in a 12-month period.
- Diagnostic casts and photographs taken for the purpose of orthodontic evaluation will be paid at the orthodontic benefit level.
- Delta Dental's obligation for payment of benefits ends on the last day of coverage. However, Delta Dental will make payment for covered services provided on or before the last day of coverage, as long as Delta Dental receives a claim for those services within one year of the date of service.

- When services in progress are interrupted and completed later by another dentist, Delta Dental will review the claim to determine the amount of payment, if any, to each dentist.
- Care terminated due to the death of an eligible person will be paid to the limit of Delta Dental's liability for the services completed or in progress.
- Optional treatment: if you select a more expensive service than is customarily provided, Delta Dental may make an allowance for certain services based on the fee for the customarily provided service. You are responsible for the difference in cost. In all cases, Delta Dental will make the final determination regarding optional treatment and any available allowance.
- Listed below are services for which Delta Dental will provide an allowance for optional treatment. Remember, you are responsible for the difference in cost for any optional treatment.
- Plastic, resin, porcelain fused to metal, and porcelain crowns on posterior teeth – Delta Dental will pay only the amount that it would pay for a full metal crown.
- Overdentures – Delta Dental will pay only the amount that it would pay for a conventional denture.
- Plastic, resin, or porcelain/ceramic inlays or onlays on posterior teeth – Delta Dental will pay only the amount that it would pay for a metallic inlay or onlay.
- All-porcelain/ceramic bridges – Delta Dental will pay only the amount that it would pay for a conventional fixed bridge.
- Implant/abutment supported complete or partial dentures – Delta Dental will pay only the amount that it would pay for a conventional denture.
- Gold foil restorations – Delta Dental will pay only the amount that it would pay for an amalgam or composite restoration.
- Stainless steel crowns with esthetic facings, veneers or coatings – Delta Dental will pay only the amount that it would pay for a conventional stainless steel crown.
- Maximum payment:
- The maximum benefits payable in any one benefit year will be limited to the maximum payment stated under contract maximum.
- Delta Dental's payment for orthodontic services will be limited to the annual or lifetime maximum payment stated under orthodontic lifetime maximum.
- Processing policies may limit Delta Dental's payment for services or supplies.

Delta Dental will make no payment for services or supplies that exceed the following limitations. All charges are your responsibility. However, participating dentists may not charge eligible persons for these services or supplies when performed by the same dentist or dental office. All time limitations are measured from the applicable prior dates of services in our records with any Delta Dental plan or, at the request of your group, any dental plan:

- Amalgam and composite resin restorations are payable once in any two-year period, regardless of the number or combination of restorations placed on a surface.
- Core buildups and other substructures are payable only when needed to retain a crown on a tooth with excessive breakdown due to caries (decay) and/or fractures.
- Recementation of a crown, inlay, onlay, space maintainer, or bridge within six months of the seating date.

- Retention pins are payable once in any two-year period. Only one substructure per tooth is a covered service.
- Root planing is payable once in any two-year period.
- Periodontal surgery is payable once in any three-year period.
- A limited occlusal adjustment is not payable more than three times in any five-year period. The fee for a limited occlusal adjustment includes all adjustments that are necessary for a six-month period.
- Tissue conditioning is payable twice per arch in any three-year period.
- The allowance for a denture repair (including reline or rebase) will not exceed half the fee for a new denture.
- Services or supplies, as determined by Delta Dental, which are not provided in accordance with generally accepted standards of dental practice.
- Processing policies may limit Delta Dental's payment for services or supplies.

SECTION 7: Exclusions

Delta Dental will make no payment for the following services or supplies, unless otherwise specified in the summary of dental plan benefits. All charges for the same will be your responsibility (though your payment obligation may be satisfied by insurance or some other arrangement for which you are eligible):

- Services for injuries or conditions payable under workers' compensation or employer's liability laws. Services received from any government agency, political subdivision, community agency, foundation, or similar entity. Note: this provision does not apply to any programs provided under title xix of the social security act; that is, Medicaid.
- Services or supplies, as determined by Delta Dental, for correction of congenital or developmental malformations.
- Cosmetic surgery or dentistry for aesthetic reasons, as determined by Delta Dental.
- Services started or appliances started before a person became eligible under this plan. This exclusion does not apply to orthodontic treatment in progress (if a covered service).
- Prescription drugs (except intramuscular injectable antibiotics), premedication, medicaments/ solutions, and relative analgesia.
- General anesthesia and intravenous sedation for (a) surgical procedures, unless medically necessary, or (b) restorative dentistry.
- Charges for hospitalization, laboratory tests, and histopathological examinations.
- Charges for failure to keep a scheduled visit with the dentist.
- Services or supplies, as determined by Delta Dental, for which no valid dental need can be demonstrated.
- Services or supplies, as determined by Delta Dental that are investigational in nature, including services or supplies required to treat complications from investigational procedures.
- Services or supplies, as determined by Delta Dental, which are specialized techniques.
- Services or supplies, as determined by Delta Dental, which are not provided in accordance with generally accepted standards of dental practice.

- Treatment by other than a dentist, except for services performed by a licensed dental hygienist or other dental professional, as determined by Delta Dental, under the scope of his or her license as permitted by applicable state law.
- Services or supplies excluded by the policies and procedures of Delta Dental, including the processing policies.
- Services or supplies for which no charge is made, for which the patient is not legally obligated to pay, or for which no charge would be made in the absence of Delta Dental coverage.
- Services or supplies received due to an act of war, declared or undeclared.
- Services or supplies covered under a hospital, surgical/medical, or prescription drug program.
- Services or supplies that are not within the categories of benefits selected by your employer or organization and that are not covered under the terms of this certificate.
- Fluoride rinses, self-applied fluorides, or desensitizing medicaments.
- Preventive control programs (including oral hygiene instruction, caries susceptibility tests, dietary control, tobacco counseling, home care medicaments, etc.).
- Space maintainers for maintaining space due to premature loss of anterior primary teeth.
- Lost, missing, or stolen appliances of any type and replacement or repair of orthodontic appliances or space maintainers.
- Cosmetic dentistry, including repairs to facings posterior to the second bicuspid position.
- Veneers.
- Prefabricated crowns used as final restorations on permanent teeth.
- Appliances, surgical procedures, and restorations for increasing vertical dimension; for altering, restoring, or maintaining occlusion; for replacing tooth structure loss resulting from attrition, abrasion, abfraction, or erosion; or for periodontal splinting. If orthodontic services are covered services, this exclusion will not apply to orthodontic services as limited by the terms and conditions of the contract between Delta Dental and your employer or organization.
- Paste-type root canal fillings on permanent teeth.
- Occlusal guards and complete occlusal adjustments.
- Chemical curettage.
- Services associated with overdentures.
- Metal bases on removable prostheses.
- The replacement of teeth beyond the normal complement of teeth.
- Personalization or characterization of any service or appliance.
- Temporary crowns used for temporization during crown or bridge fabrication.
- Posterior bridges in conjunction with partial dentures in the same arch.
- Precision attachments and stress breakers.
- Bone replacement grafts and specialized implant surgical techniques, including radiographic/surgical implant index.
- Appliances, restorations, or services for the diagnosis or treatment of disturbances of the temporomandibular joint (TMJ).
- Diagnostic photographs and cephalometric films, unless done for orthodontics and orthodontics are a covered service.

- Myofunctional therapy.
- Mounted case analyses.

Delta Dental will make no payment for the following services or supplies. Participating dentists may not charge eligible persons for these services or supplies. All charges from nonparticipating dentists for the following are your responsibility:

- The completion of forms or submission of claims.
- Consultations, patient screening, or patient assessment when performed in conjunction with examinations or evaluations. Local anesthesia.
- Acid etching, cement bases, cavity liners, and bases or temporary fillings.
- Infection control.
- Temporary, interim, or provisional crowns.
- Gingivectomy as an aid to the placement of a restoration.
- The correction of occlusion, when performed with prosthetics and restorations involving occlusal surfaces.
- Diagnostic casts, when performed in conjunction with restorative or prosthodontic procedures.
- Palliative treatment, when any other service is provided on the same date except x- rays and tests necessary to diagnose the emergency condition.
- Post-operative x-rays, when done following any completed service or procedure.
- Periodontal charting.
- Pins and preformed posts, when done with core buildups for crowns, inlays, or onlays.
- A pulp cap, when done with a sedative filling or any other restoration. A sedative or temporary filling, when done with pulpal debridement for the relief of acute pain prior to conventional root canal therapy or another endodontic procedure. The opening and drainage of a tooth or palliative treatment, when done by the same dentist or dental office on the same day as completed root canal treatment.
- A pulpotomy on a permanent tooth, except on a tooth with an open apex.
- A therapeutic apical closure on a permanent tooth, except on a tooth where the root is not fully formed.
- Retreatment of a root canal by the same dentist or dental office within two years of the original root canal treatment.
- A prophylaxis or full mouth debridement, when done on the same day as periodontal maintenance or scaling and root planing.
- An occlusal adjustment, when performed on the same day as the delivery of an occlusal guard.
- Reline, rebase, or any adjustment or repair within six months of the delivery of a partial denture.
- Tissue conditioning, when performed on the same day as the delivery of a denture or the reline or rebase of a denture.

SECTION 8. Definitions

This section defines terms that have special meanings. If a word or phrase has a special meaning or it is a title, it starts with a capital letter. The word or phrase is defined in this section or at the place in the text where it is used.

Benefit period - a 12-month period of time listed in the schedule of benefits.

Certificate - the term certificate means this document.

Certificate holder - an eligible person who has enrolled for coverage.

Contract - the agreement (including the group application and any riders) between your group and us, referred to as the master contract or group contract.

Contract date - the date when coverage for the group starts.

Co-insurance - a percentage of the maximum approved fee for which you are responsible per covered service after you meet an applicable deductible in each benefit period.

Covered person - the certificate holder, and if family coverage is in force, the dependents.

Covered service - a service or supply shown in the certificate and given by a provider for which we will provide benefits. A covered service may be subject to a deductible or co- payment. To be a covered service, services must be:

- Authorized by a physician;
- Medically necessary, except as otherwise specified in this certificate;
- Consistent with the condition(s) for which you were admitted when an inpatient; and,
- Within the scope of the license of the provider performing the service.

Deductible - if applicable, is an amount of covered services, stated in dollars, for which you are responsible before we start to pay each benefit period.

Dental hygienist - a person who is licensed to practice dental hygiene and is working under the supervision and direction of a dentist.

Dentist - a person who is licensed to practice dentistry.

Dependent - a covered person other than the certificate holder as defined in the medical section, under eligibility.

Effective date - the date when your coverage begins under this certificate.

Eligible person - a person who satisfies the requirements of the group contract and is entitled to apply to be a certificate holder.

Experimental/investigative - any drug, device, equipment, facility, procedure, treatment, or supply (hereafter called service) which we, in our discretion, may determine with regard to a particular illness, disease or condition:

- Did not have governmental approval for marketing at the time when furnished for the purpose or manner rendered; or
- Is not supported by reliable evidence which shows that the service:
- Is generally recognized as being safe and effective for treating the condition in question by those practicing the appropriate medical specialty;
- Has a definite positive effect on health outcomes;
- Over time leads to improvement in health outcomes under standard conditions of medical practice outside clinical investigatory settings (i.e., the beneficial effects outweigh any harmful effect); and
- Is at least as effective as standard means of treatment in improving health outcomes, or is usable in appropriate clinical contexts in which standard treatment means is not employable.

Reliable evidence includes only:

- Published reports and articles in authoritative medical and scientific literature;
- The written investigational or research protocols and/or the written informed consent used by the treating facility or of another facility which is studying the same service; and
- Compilations, conclusions and other information which we have available which are drawn from (1) or (2) above.he city has the authority and discretion to determine all questions in connection with whether any service is experimental/investigative under this certificate.

Family coverage - coverage for the certificate holder and one or more dependents.

Identification card - the card which is provided to you, and contains your identification number.

Incurred - a charge will be considered incurred on the date a covered person receives the service or supply for which the charge is made.

Individual coverage - coverage for the certificate holder only.

Medically necessary (or medical necessity) - a service or supply given by a provider that is required to diagnose or treat your condition, illness or injury and which we determine is:
Appropriate with regard to standards of good dental practice;
Not solely for the convenience of you or a provider;
The most appropriate supply or level of service which can be safely provided to you.

Other Provider - the following persons or entities which are licensed, where required under applicable state laws, to render covered services:
Professional other providers

Physician - one of these professionals licensed under applicable state laws:

- Doctor of medicine (M.D.)
- Dental surgeon (D.D.S.)
- Dentist (D.M.D.)

Professional Other Providers - the following persons or entities which are licensed, where required under applicable state laws, to render covered services:

- Dental Hygienist

Provider - a Licensed Physician or Professional Other Provider.

Medicare Approved Provider - a provider that is certified by the United States Department of Health and Human Services to receive payment under the Medicare program.

Participating Provider - a physician or professional other provider that has a written agreement with a Delta Dental plan, either Delta Dental PPO or Delta Dental premier, about payment for covered services.